Colleagues in Caring
South Dakota Consortium
Marge Hegge, Project Director ❖ SDSU Box 2218 ❖ Brookings, SD 57007-3501 ❖ 605-688-6740

Hospitals

White Paper by Mina Hall and Nancy Nelson
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Introduction

Increased technology, implementation of managed care, pressure to improve or maintain the bottom line, changes in reimbursement, a competitive market place as well as downsizing, acquisitions and mergers have placed demands on hospitals to provide high quality care as cost effectively as possible. The patients that remain in the hospital are generally sicker and require a higher intensity of nursing care. These changes have resulted in some dramatic changes in hospital structures, services and source of patient care services in South Dakota. South Dakota, like the rest of the nation, is moving towards more of the care being provided in a community setting rather than within the hospital walls and with a renewed emphasis on primary care. The major emphasis on health care is still on the acute side of the continuum but with cost containment pressures and the push for primary care; hospitals are collaborating with community-based organizations for services to complete the continuum of care.[1] Many hospitals have established community based services to help support this shift in the location of care.

Definitions

The South Dakota Department of Health provided the following definitions.[2,3]

- **Hospitals** will be defined as any establishment with an organized medical staff with permanent facilities that include inpatient beds and primarily engaged in providing by or under the supervision of physicians, to inpatients, any of the following services: diagnostic or therapeutic services for the medical diagnosis, treatment or care of injured, disabled, or sick persons; obstetrical services including the care of the newborn; or rehabilitation services for rehabilitation of injured, disabled, or sick persons.
- **Hospitals with a specialty license** have limited services and do not offer full service. Some rural hospitals have dropped some of their services due to a variety of reasons, such as cost, so they are now licensed as specialty hospitals.
- **Hospitals with specialized services** is the correct terminology for surgical hospitals, rehab hospitals, etc. This includes Aberdeen's Dakota Plains Surgical Center, the Siouxland Surgery Center at Dakota Dunes, Rapid City's Black Hills Rehabilitation Hospital, the Black Hills Surgery Center, and Same Day Surgery Center; while

Sioux Falls is home to the Children's Care Hospital and School, the Select Specialty Hospital and the Sioux Falls Surgical Center and Yankton has the Human Services Center. Another hospital with specialized services is planned to open in December 2000 in Sioux Falls.

- **Community hospitals** are non-federal, short-term general hospitals whose facilities and services are available to the general public.
- **Non-community hospitals** provide varying degrees of emergency, acute, intensive, skilled nursing or specialty care. They usually have access requirements or are specialized in the nature of care they provide. All have the capability of providing acute care, which differentiates them from nursing facilities, which do not have this capability. Non-community hospitals include the two Veteran's Administration Services Hospitals, the military hospital at Ellsworth, the five Indian Health Services Hospitals and the eight specialty hospitals. Only the specialty hospitals are licensed by the state of South Dakota.
- **Swingbeds** are community hospital beds that have been licensed for acute care but are also approved by the South Dakota Department of Health for the provision of short-term nursing care. The beds must meet the conditions of being in a hospital located in a rural area that has fewer than 100 acute care beds.

History

The most dramatic change in facilities since the last white paper was written is the increase in hospitals with specialty services and specialty hospitals.

The number of community hospitals has declined in recent years from a high of 54 in 1988 to 50 by 1999**.** Of the 50 community hospitals**,** 45 are licensed for swingbeds. The average size of a community hospital is 62.4, though most are relatively small with a median size of 27.5 beds. The smallest hospital has 4 beds while the largest has 537 beds. There are 19 hospitals that have between 4-24 beds, 20 with 25-49 beds, 4 with 50-99 beds, 4 with 100-199 beds, and 3 that have greater than 200 beds. The number of beds decreased during the past ten years from 3,501 to 3,120. In addition to the 50 community hospitals, there are 16 non-community hospitals with approximately 885 total beds.[3]

The average length of stay in a community hospital, without swingbed days, went from 5.7 to 4.8 days over the past ten years. The average length of stay including swingbed days during these past 10 years also decreased from 6.15 days to 5.00 days.

Persons admitted to a non-community hospital stay in the hospital longer than those admitted to a community hospital. However, the average length of stay decreased from 23.10 days in l993 to 14.90 days by l999. This dramatic decrease was attributed, in part, to the decrease in beds at the Veteran's Administration Hospitals.[3]

Cost containment efforts by government, health care coverage companies and hospitals have encouraged the utilization of outpatient procedures and thus decreased the period of time people stay in the hospital. The increase in outpatient visits since 1994 with 961,331 increased to 1,492,725 by 1999. As a result, inpatient utilization continues to decrease with a slight decrease in inpatient days and length of stay. Occupancy rates declined as a

result of the decrease in acute care admissions and decreased lengths of stay. Hospitals with more than 200 beds have the highest occupancy percent rate, while hospitals with less than 24 beds have the lowest percent. The occupancy rates have declined by 2.6 percent since 1989.[3]

One of the best measures of availability is the number of community hospital beds per 1,000 population. In South Dakota, the number has fluctuated over the years from 4.4 beds in 1950 to 5.6 beds in 1970, and by 1999 we had 4.48 beds per 1,000 population.[3] By 1998, South Dakota had an FTE of 534.25 Primary Care Physicians (Family Practice, Internal Medicine, Pediatrics, Obstetrics/Gynecology and General Practice) and 292.25 FTE of Physician Assistants/Nurse Practitioners/Certified Nurse Midwives.[4]

In summary, several communities in South Dakota had two hospitals that experienced a merger of the two facilities. The newly formed single hospital became part of a system of healthcare and often became the referral site for smaller outlying communities. The smaller more rural hospitals also joined systems or entered into affiliation agreements with the larger centers to increase cost efficiency. However, even this measure does not guarantee continued survival as hospitals are closing in small rural areas such as the hospitals in Belle Fourche and Hot Springs. The affiliations, ownership, partnerships and networks within systems have increased to include nursing facilities, rural health clinics, surgery centers and physician clinics. Many of the outpatient clinics have expanded their services. Many hospitals downsized their inpatient beds, restructured nursing care systems, increased the number of unlicensed personnel on staff and are now seeking ways of remaining financially solvent as the effects of the Balanced Budget Act are being anticipated.

Current Reality (Internal Factors)

Skill sets across settings/practice are changing dramatically for the Registered Nurse (RN), the Licensed Practical Nurse (LPN) and the Advanced Practice Nurse (APN) as more patients are being treated in out-patient settings with only the acutely ill being treated in the hospital. Patients are requiring a higher intensity of nursing care and skill level.

The lengths of stay in hospitals have decreased resulting in the initiation of patient education and discharge planning almost immediately upon admission and with a team or multidisciplinary approach utilizing expertise from all areas of the hospital. Case management has become an integral part of the nurse's role and interdisciplinary patient care is a must for smooth transition of the patient to the next phase in the healthcare plan. The VA has experienced an aging in their patient population that has increased the time and resources needed to maintain the health status of their patients.

The emerging diseases/conditions that are being noted include a shift in the chronic care that has expanded to include a spectrum of integrated services (medical, personal, social and rehabilitative). There has been an increase in MDRO (multiple drug resistant organisms), antibiotic resistant microorganisms and a resurgence of tuberculosis (TB). The leading causes of death in South Dakota are cardiovascular diseases, cancer, chronic obstructive pulmonary disease, injuries, suicide and infant and fetal mortality.

The national movement regarding palliative care and the need for education to both consumers and health care providers will impact both the ethical issues and the financial issues associated with end of life care.

The demand for holistic assessments of families within communities is evident as quality of life issues, patient rights and ethical dilemmas are common occurrences in our healthcare environment today. The need to have access and availability of both hospital and post-hospital care in all areas of the state is a concern as we deal with the ruralness of the state and the localization of many of these facilities in the more densely-populated regions. With the closure of some of the small hospitals, fewer services are available and accessibility is becoming even more pronounced in the rural areas.

Patients using the Veterans Administration Services, like many others, have limited financial and family resources and require home care that can be referred to community health agencies in or near their homes. The Veterans Administration strives to place a veteran in a post hospital facility in or as near their hometown as possible. The need for nursing care will be increased as the veteran population ages. The Veterans Administration System opened satellites in Pierre and Rapid City with additional proposed sites in Sioux City, Iowa, Aberdeen and Watertown and in Southwest Minnesota.

Trends in the Indian Health Services (IHS) indicate more health care services will be provided in outpatient-ambulatory and home health settings. IHS facilities will experience similar trends of a decreasing average daily patient census, as is the case for all hospitals across the United States.

Current Reality (External Factors)

Economic pressures are encouraging hospitals to downsize in the face of the continuing shift of patient care to outpatient settings. Other economic pressures include the capitation of government payment sources (Medicare/Medicaid/Others), point of service and Medicare select are all dramatically influencing today's health care system.[5] Although third-party payers are the largest source of patient service revenue; there has been a noted increase in the number of uninsured/under-insured in recent years. The Children's Health Insurance Plan, the Medicaid program for uninsured children, was expanded to include children under the age of 19 and up to 140% of poverty. This program has not yet reached its full potential for coverage.

Competition is increasing for hospitals from the private sector with the advent of freestanding specialty/niche or surgi-centers. Specialty hospitals may create another economic hardship on the community hospitals. There is concern that for-profit hospitals may not have the commitment to the community that is inherent in the more traditional not-for-profit community hospitals.[6]

There will continue to be a development of partnerships between hospitals and community agencies as well as between hospitals and nursing facilities. The effort to provide a continuum of care for patients will increase as the demand for an efficient and effective health care system continues.

The advent of for-profit managed care will have a significant impact upon hospitals if it blossoms to a greater extent than is currently experienced. HMOs will continue to become more evident in South Dakota especially in the larger cities.

In Veterans Administration (VA) institutions, predictions are that acute care beds will continue to decrease and VAs will either close or consolidate with other VAs. The Veterans Administration Systems have set the goal of having 80% of all surgeries done on an outpatient basis. Smaller VA hospitals will have services such as ambulatory care as well as limited acute care and critical care beds. Community based outpatient clinics will impact the larger facilities. Clinical pathways will be used to manage uncomplicated patient cases while complicated cases will be case managed. Patients who need major surgery or services that cannot be provided at a local Veteran Administration facility will be transferred to a tertiary Veterans Administration hospital.

In Indian Health Services, a portion of the 158 acute care beds will be converted to swing beds and same-day surgery units. There will be an increase in shared services among and between the Indian Health Service inpatient facilities located in South Dakota, as well as other Indian Health Service facilities located in North Dakota or Nebraska that specialize in certain areas of expertise. Ambulatory care clinics will be expanded in the areas of urgent care, women's health and adolescent health care. There will be an expansion of home health and hospice services where currently limited services are provided.

Since the white paper was initially written in l997, the nursing shortage has become a reality in South Dakota. Some hospitals are paying a recruitment sign-on bonus and other incentives to entice nurses to their institution. Others are looking at recruitment and retention issues. The shortage impacts the workload and staffing ratios of all nurses and could impact the quality of care.

Implications for Nursing Practice

In the Veterans Administration Systems, a congressionally-mandated downsizing of federal government began with the Clinton Administration in 1992. To meet these mandates, many mid-level manager positions have been eliminated, positions and departments have been combined or eliminated and early retirements have been offered. These workforce changes have implications for veterans including a potential reduction in health care and benefits. The VAs had recommended a two hundred percent (200%) increase in mid-level practitioners and are working on five million dollars to assist with enhancing the nurses' education to a baccalaureate level. It will take approximately five years to complete the educational process as about fifty percent of their nursing staff currently has an associate degree. They are utilizing more advanced practice nurses and physician assistants.

In the Indian Health Services, registered nurses will be utilized more in the case manager role and independent practitioners, such as advanced practice nurses, will play a more dominant role in the delivery of patient care. There will be an increased focus on outcomes and clinical pathways in most of the IHS facilities.

In community hospitals, there was a shift in place or type of employment for nurses within the hospital structure. More nurses are being utilized in positions of management of

services, infection control, case managers, staff development, utilization review and discharge planners. The shift of some to community and family based health settings was more pronounced in the early 1990s but with the current payment reductions for homecare, some nurses are returning to the hospital environment. The practice of the RN will become more autonomous with an increased need for critical thinking skills. Collaborative practice, clinical pathways, cross-training in several areas and differentiated practice models will be utilized between units as well as between institutions to assist in providing the patient with an efficient system of healthcare. There will be a redesign of management structures with positions previously held by nurses either being eliminated or replaced with non-nurses. The use of unlicensed personnel at the bedside will increase with fewer nurses to supervise the care.

LPN positions in all hospitals have been dramatically reduced in recent years with many LPNs going back to school to become RNs or re-locating into physician clinics and nursing facilities. This has been evident by an increased employment of unlicensed assistive personnel with fewer LPNs in hospitals.

According to Colleen Conway-Welch's analysis of the Pew Health Profession Commission's (1995) Report,[7.] "Critical Challenges: Revitalizing the Health Professions for the 21st Century," it was determined that the environment in which the nurse was working would become irrelevant. Rather, the nurse must be able to: move patients across the continuum of care, become involved in outcomes-based research and process technology and demonstrate expertise in continuous improvement techniques. The nurse will design patient care approaches that are satisfactory to patients, families and managed care organizations; will direct interdisciplinary teams; and be highly skilled in information systems technology. The nurse will develop, collect and analyze data to define, refine, and improve patient care and use data to benchmark and improve clinical outcomes. The nurse will need to understand resource allocation and management.[8]

Implications for Nursing Education

As a result of the closing and downsizing of hospitals and the work of nursing shifting, educational programs are seeking clinical experiences for the students in community settings as well as the traditional hospital settings. Curriculum changes in all levels of preparation include critical thinking, assessment skills, pain management, community nursing, leadership and delegation. Mentors need to be recruited that are willing and prepared to assist in the education of the students. Enrollment limits may have to be implemented to make sure the appropriate numbers of nurses are being prepared at the appropriate level with the appropriate skill sets to meet the needs of the hospitals, patients and communities especially during this nursing shortage crisis when pressures are placed on schools of nursing to graduate greater numbers.

Articulation measures that ensure a greater ease in access for LPNs and RNs to obtain an advanced degree are being discussed to help meet the demand for nurses with a baccalaureate degree or higher. There has been a dramatic decline in the number of nurses enrolling or returning to school for an advanced degree. Assistance in terms of financial support, flexible work hours, and enhanced long distance learning opportunities must be

provided. Educational opportunities to assist the nurse in making the transition of work environments will be essential to help the current workforce obtain the educational and clinical preparation they need for their changing work environment. The Internet education programs being offered may provide at least a partial solution to the distance problem for the non-traditional student. Some areas will need to provide or recruit nurses to meet the specialty training needed to meet the demands of the new positions. A renewed dedication by hospitals and communities for tuition assistance and loan programs will be needed to help obtain this specialty or advanced degree education.

The number of LPNs seeking upward mobility has declined and schools are seeking ways to make articulation more accessible to those that wish to seek this option. There has been an impact on schools that traditionally had a larger enrollment specifically designed for LPNs with a "career ladder" that recognized previous education. Discussion is occurring regarding the establishment on a broader scope of service for the LPN and integrating those responsibilities into the current curriculum. The need for an additional school for LPNs is being explored in the Pierre area, as currently the two schools are located in Watertown and Rapid City.

Implications for Nursing Regulation

Nursing regulations will need to address the utilization and scope of practice of the unlicensed/underprepared nurses. There may need to be greater differentiation in the scope of practice, depending upon the educational preparation and the setting in which the nurse is practicing. Regulations may need to provide more latitude in dealing with the anticipated increased level of autonomy in which the nurse will practice.

As hospitals form alliances, networks and organize into systems which may cross-state lines, there will be a need for a multi-state licensure. A multi-state licensure task force with representation from educators, regulators, professional groups, health care organizations, legislators and community studied this issue in 1998-99. The multi-state license practice is already in existence on the reservation and in the Veterans Administration System. The South Dakota Board of Nursing is providing education regarding the implications of multi-state licensure.

The LPN Task Force is examining the LPN scope of practice to determine if the expanded practice role should be incorporated into the basic role.

The Delegation Task Force is revising the delegation rules as they relate to Unlicensed Assistive Personnel.

Implications for the Nursing Workforce

There will be an increase in flexibility with a less structured work environment that will encourage nurses to work independent of the typical structure of hospital walls and policies. This also means less support in terms of administration, co-workers, resources and in-house opportunities for education. Responsibility for obtaining educational expertise in their areas of practice will be increased even if continuing education hours are not mandated for licensure.

The nursing workforce will need to become stronger consumer advocates and possess a heightened awareness of community resources. Nurses everywhere will need to provide health promotion and prevention activities for the community and encourage the consumers to take an active role in their healthcare management. Consumers will be obtaining information from Internet sources and will be better informed when seeking healthcare.

There is and will continue to be a difference in the roles of community nursing and public health, and nurses need to be an active participant in both fields. Tele-medicine and tele-nursing will link rural communities and nurse providers with large system networks. Nurses in rural areas face special challenges due to the unique demands of their location. They must be expert generalists because of the range of skills and knowledge required. Rural nurses also face a host of threats from the political, social and financial environments.

Hospital nursing is more technical and intense, and RNs will need highly technical skills and coping strategies to contend with the continual change in technology and acuity of the patient. Hospitals will employ fewer LPNs and more Advanced Practice Nurses in the future. There are risks for the RN with more UAPs to supervise and to whom tasks are delegated. Nurses need to fully understand their nursing practice acts and standards of practice to implement safe and appropriate care in spite of high acuity and staffing ratios.

Nurses working in VA facilities will be emphasizing patient education including primary prevention and adult immunizations. Understanding of community resources for the veterans will be essential in returning the patient back to their community as lengths of stay in VA hospitals are also declining.

Since nurses are the largest group of healthcare providers in South Dakota, it makes sense and is imperative that nurses prepare and help deliver the care needed by consumers in a variety of community settings. Nurses will be the cornerstones of essential service facilities in small communities. There are now Advanced Practice Nurses available in all but about twelve (12) of the sixty-six (66) counties in South Dakota, a dramatic increase in the past four years.[9]

Implications for Nursing Research

Nursing research implications were identified in many areas including the issue of pain management and palliative care. The issues of medication safety and effects of MDRO on patients and the healthcare population are of national concern. Nursing care implications during times of nursing shortages need to be addressed proactively with research into efficient nursing care delivery models and the effects of fatigue and stress on the nursing staff. Research related to the ethical and political issues associated with budget and staffing limitations in healthcare. Cultural adaptations in teaching materials for Native American nursing students and for patient education needs to be researched and developed if nurses are to influence the healthcare of nearly nine percent of the state's population. Clinically-relevant research with nursing expertise continues to be a need as nurses strive to provide evidenced-based practice.

Revised copy of the l997 White Paper

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